210-RICR-20-00-1

TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 20 – MEDICAID PAYMENTS AND PROVIDERS

SUBCHAPTER 00 – N/A

PART 1 – MEDICAID PAYMENTS AND PROVIDERS

1.1 Legal Authority

A. The Rhode Island Medicaid Program provides health care coverage authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396w-~~8~~87 (Federal Medicaid Law), and Title XXI of the Social Security Act, 42 U.S.C. §§ 1397aa-1397mm (Federal Children's Health Insurance Program ("CHIP") law), as well as the State's Medicaid State Plan and Section 1115 demonstration waiver granted under the authority of § 1115 of the Social Security Act, 42 U.S.C. § 1315. To participate in the Medicaid program, ~~health care~~ providers must be ~~certified~~ qualified and agree to abide by the requirements established in federal law, Rhode Island General Laws, and State and Federal Rules and Regulations.

B. To qualify for Federal matching funds, payments to ~~certified~~ qualified providers for authorized services must be made in accordance with methodologies established by the State and approved for such purposes by the Secretary of the U.S. Department of Health and Human Services (~~D~~HHS) and/or the Federal Centers for Medicare and Medicaid Services (CMS). The Secretary of the EOHHS is authorized to set forth in Rule, contractual agreements, provider certification standards, and/or payment methodologies the requirements for obtaining Federal financial participation established in Federal laws, Regulations, or other such authorities. This Rule governs participation of and payments to ~~health care~~ providers participating in the Medicaid program.

1.2 Incorporated Materials

A. These Regulations hereby adopt and incorporate 42 C.F.R. § 424.518 (2025~~3~~4) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these Regulations.

B. These Regulations hereby adopt and incorporate 42 C.F.R. Part 431 (2025) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these Regulations.

C. These Regulations hereby adopt and incorporate 42 C.F.R. Part 433 (2025) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these Regulations.

D. These Regulations hereby adopt and incorporate 42 C.F.R. Part 438, Subpart H (2025) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these Regulations.

E. These Regulations hereby adopt and incorporate 42 C.F.R. Part 447 (2025) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these Regulations.

F

G. These Regulations hereby adopt and incorporate 42 C.F.R. 489.18(a) (2025) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these Regulations.

~~C. These Regulations hereby adopt and incorporate 42 C.F.R. § 1002.214 (2021) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these Regulations.~~

1.3 Definitions

A. As used in this Rule, the following terms and phrases have the following meanings:

1. "Authorized agent" means a person who has been appointed and delegated the legal authority to bind, obligate, commit, or act on behalf of a provider for the purposes of the provider's status in the Medicaid program. For organizational providers, this may include an owner, officer, or managing employee. For individual providers, the only authorized agent is the provider.

2. "Conviction" means as assigned in R.I. Gen. Laws §§ 42-7.2-18.2 and 42-7.2-18.4.

3. "Day" or "days" means calendar day(s) unless otherwise specified.

4. "Denial" means the rejection of an application submitted by a newly enrolling provider.

5

6~~3~~. "High-risk provider" means a provider that poses a high risk of fraud, waste or abuse. These providers are:

a. Community Health Worker (CHW);

b. ~~D~~Designated by the Centers for Medicare and Medicaid Services as high categorical risk according to 42 C.F.R. § 424.518 (2025~~4~~)~~:~~;

i. Newly enrolling durable medical equipment (DME), home health agency, hospice, or nursing facility providers;

ii. Providers elevated to high-risk based upon the imposition of a payment suspension based upon a credible allegation of fraud, moratorium, overpayment, involuntary termination, or exclusion with by the Office of Inspector General, Medicare, EOHHS, or another state Medicaid agency;

iii. Revalidating DME, home health agency, hospice, or nursing facility providers where fingerprinting has not been completed as required under this Part.

c~~b~~. Home care;~~—~~

d. Individual personal care attendants and homemakers providing direct care to individuals under the EOHHS Personal Choice program, Chapter 50-10-2 of this Title;

e. Pediatric private duty nursing;

f~~c~~. Shared living caregivers providing direct care to individuals under the EOHHS Shared Living program, Chapter 50-10-1 of this Title.~~; and~~

7~~d. Community Health Workers (CHWs).~~

8. "Limited-risk provider" means a provider that is neither a moderate-risk provider nor a high-risk provider.

9. "Managing employee" means a general manager, business manager, billing manager, office manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts or supervises the day-to-day operations of a provider, regardless of whether the individual is a W-2 employee. For providers subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA), codified at 42 U.S.C. § 1866 and applicable to the Medicaid program under § 1902(a)(9) of the Social Security Act, 42 U.S.C. § 1396a(a)(9), the lab director is considered a managing employee.

10~~5~~. "Moderate-risk provider" means a provider that poses a moderate risk of fraud, waste or abuse. These providers are:

aa. Adult day health;

b. Center of Excellence;

c. Certified Community Behavioral Health Clinic (CCBHC);

d. Conflict-free case management (CFCM);

e. Designated by the Centers for Medicare and Medicaid Services as moderate categorical risk according to 42 C.F.R. § 424.518 (2025):

i. Ambulance;

ii. Community Mental Health Center (CMHC)/rehabilitation;

iii. Independent laboratory;

iv. Physical therapist enrolling as an individual or a group;

v. Revalidating DME, home health agency, hospice, or nursing facility where fingerprinting has been completed as required under this Part; and

vi. Substance use rehabilitation;

f. Emergency behavioral health;

g. Home and center based therapeutic service (HBTS);

h. Peer recovery services; and

i. Psychiatric Residential Treatment Facility (PRTF). Providers designated by the Centers for Medicare and Medicaid Services as moderate categorical risk according to 42 C.F.R. § 424.518 (2024);

12. "Owner" means a person or business that possesses equity in the capital, stock, or profits of a provider. This includes a sole proprietor, partner in a provider that is organized as a partnership, member of a limited liability company, and shareholder of a corporation.

13. "Provider" means any individual or entity including physicians, nurse practitioners, physician assistants, and others who that are is engaged in the delivery of Medicaid-funded medical/behavioral health care items or services, or ordering, prescribing, or referring (OPR) for those items or services, and is legally authorized to do so by the State in which the provider delivers the services. This includes fee-for-service and managed care providers.

14. "Provider type" means the categorization of a provider for Medicaid billing purposes based on the services the provider is qualified and authorized to provide according to state and federal standards. Rhode Island Medicaid recognizes the following provider types:

Adult Behavioral Health Group	Hospital, including inpatient, outpatient, psychiatric, and Eleanor Slater Hospital
Adult Day Health	Independent Laboratory
Ambulance	Indian Health Service
Assisted Living Residence	Intermediate Care Facility
Audiologist	Lead Center
Case Management, including Conflict-Free Case Management (CFCM)	Licensed Dietician/Nutritionist
CEDARR Family Center	Licensed Therapist
Center of Excellence	Local Education Agency (LEA)
Certified Community Behavioral Health Clinic (CCBHC)	Nurse Anesthetist
Child Behavioral Health Group	Nurse Practitioner
Chiropractor	Nursing Facility
Community Health Worker (CHW)	Occupational Therapist
Community Mental Health Center (CMHC)/Rehabilitation	Optician
Department of Children, Youth and Families (DCYF) Provider, including home-based and congregate care	Optometrist
Dental Hygienist	OPR Only
Dentist	Pediatric Private Duty Nursing

Formatted: Indent: Left: 0", First line: 0"

Formatted Table

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0", First line: 0"

Developmental Disability Organization (DDO), including Rhode Island Community Living and Supports (RICLAS)	Pediatric Therapeutic Service
Dialysis Center	Peer-Based Recovery
Doula	Personal Choice Fiscal Intermediary
Durable Medical Equipment (DME), including Personal Emergency Response System (PERS)	Pharmacy
Early Intervention	Physical Therapist
Emergency Behavioral Health	Physician
Federally Qualified Health Center	Physician's Assistant
Freestanding Ambulatory Surgical Center	Podiatrist
Habilitation - Day Program	Program of All Inclusive Care for the Elderly (PACE)
Habilitation - Group Home	Psychiatric Residential Treatment Facility (PRTF)
Home and Center Based Therapeutic Services (HBTS)	Psychologist
Home Care Agency	Rite Share Provider
Home Health Agency	Rural Health Clinic
Home Meal Delivery	Shared Living Agency
Home Stabilization	Speech Language Pathologist
Hospice	Substance Use Rehabilitation

15. "Revalidation" means the renewal of provider enrollment status through the resubmission and recertification of the accuracy of enrollment information.

16.

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0", First line: 0"

~~7.~~ "Rhode Island Medicaid program" means a combined State and Federally funded program established ~~on July 1,1966,~~ under the provisions of 42 U.S.C. §§ 1396-1396w-~~7~~8, 42 U.S.C. §§ 1397aa-1397mm,~~. The enabling State legislation is to be found at~~ and R.I. Gen. Laws Chapter 40-8, as amended.

17.~~8.~~ "Secretary" means the ~~Rhode Island~~ Secretary of the Rhode Island Executive Office of Health and Human Services (EOHHS) who is responsible for the oversight, coordination, and cohesive direction of State-administered health and human services, including the ~~Medicaid agency~~Rhode Island Medicaid program, and for ensuring all applicable laws are executed under R.I. Gen. Laws § 42-7.2-5.

18

19. "Subcontractor" means as assigned in 42 C.F.R. § 455.101 (2025).

20. "Termination" means deactivation of provider enrollment status and billing privileges.

1.4 Medicaid Payment Policy

A. Medicaid is the payor of last resort under § 1902(a)(25) of the Social Security Act, 42 U.S.C. § 1396a(a)(25), and 42 C.F.R. Part 433 (2025). Community, public, and private resources such as Federal Medicare, Veteran's Administration benefits, accident settlements, or other health insurance plans must be utilized fully before payment from the Medicaid program can be authorized, including for prenatal services, labor, delivery, and postpartum care services. However, the State makes payments without regard to third (3rd) party liability for pediatric preventive services, unless the State has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for ninety (90) days. The State may also make payments without regard to potential third (3rd) party liability for up to one hundred (100) days for claims related to child support enforcement beneficiaries.

B. Payments to ~~physicians and other~~ Medicaid providers ~~of medical services and supplies~~ are made in accordance with contractual arrangements with health plans or on a fee-for-service basis in accordance with applicable Federal and State Rules and Regulations, the Medicaid State Plan, and the State's Section 1115 demonstration waiver granted under the authority of § 1115 of the Social Security Act, 42 U.S.C. § 1315.

C. Payments to Medicaid providers represent full and total payment pursuant to 42 C.F.R. § 447.15 (2025). Medicaid providers are prohibited from charging Medicaid members any membership fees as part of a Medicaid member's participation in services and from otherwise seeking payment from a Medicaid member for covered services beyond any permitted cost sharing amounts as

determined by EOHHS. No supplementary payments are allowed, except as specifically provided in the contract. ~~Direct reimbursement to recipients is prohibited except in specific circumstances to correct a denial that is reversed on appeal.~~

D. Medicaid payment is only made for services actually rendered by the provider. Under 42 C.F.R. § 447.45 (2025), providers must submit claims for Medicaid within one (1) calendar year from the date of service.

1.5 Long-term Care Facilities – Surveys

A. The Rhode Island Department of Health surveys all Nursing Facilities (NF) and Intermediate Care Facilities for persons with Intellectual Disabilities (ICF/ID) for compliance with the Federal participation requirements of the Medicare and Medicaid programs. As a result of these surveys, reports are issued for certification purposes which cite provider deficiencies, if any exist, together with appropriate plans of correction. Subsequent corrections of deficiencies are also reported.

B. Statements of provider deficiencies must be made available to the public as follows:

1. Nursing Facilities (NF) – To the extent permitted by law, reports are sent to the Social Security Administration (SSA) district office that covers the area in which the facility is located and the Medicaid agency.

2. Intermediate Care Facilities/Intellectual Disabilities (ICF/ID) – Reports are sent to the Medicaid agency. The agency is required to send the reports for both Nursing and Intermediate Care Facilities to the appropriate Long-term Services and Supports (LTSS) Unit covering the district in which the facility is located. The agency must also send the ICF/ID reports to the SSA office covering the catchment area in which the facility is located.

C. These files are available to the public upon request. Material from each survey must be held at both the EOHHS and the LTSS Unit for three (3) years.

1.6 Provider Eligibility – Enrollment and Screening Requirements

A. Enrollment Requirement

1. Unless an exception applies as specified herein, each provider furnishing items or services to Medicaid beneficiaries, or ordering, prescribing, or referring (OPR) for those items or services, must enroll with EOHHS under the appropriate provider type as a condition of Medicaid payment for such items or services, in accordance with §§ 1902(a)(78), 1902(kk), and 1932(d) of the Social Security Act, 42 U.S.C. §§ 1396a(a)(78), 1396a(kk),

and 1396u-2(d), and implementing regulations at 42 C.F.R. Part 455, Subpart E (2025) and 42 C.F.R. § 438.602 (2025).

2. Exceptions to the enrollment requirement:

a. Out-of-state managed care providers may receive payment without enrolling with Rhode Island Medicaid if the provider is enrolled in Medicare or another state's Medicaid program and the claim represents either a single instance of care furnished over a 180-day period or multiple instances of care furnished to a single beneficiary over a 180-day period. The provider must enroll to receive payment for any subsequent episodes of care, or single episodes of care exceeding 180 days. The 180-day rule does not apply in fee-for-service; fee-for-service providers must enroll to receive payment even if for single instances of care.

b. Managed care network providers may receive payment for services rendered for up to 120 days after submission of a complete application but before the completion of enrollment and screening activities. Payments must cease immediately if EOHHS denies the enrollment within the 120 days.

B. Basic Eligibility Requirements

1. EOHHS has the authority to set reasonable standards relating to provider qualifications under 42 C.F.R. § 431.51(c)(2) (2025).

2. To be eligible to participate in the Rhode Island Medicaid program as any provider type, a provider must:

Formatted: RICR Paragraph 2

a. Be located and performing services in the State of Rhode Island or a bordering community as defined in Part 20-00-3 of this Title, unless out-of-state participation is approved in accordance with Part 20-00-3 of this Title and 42 C.F.R. § 431.52 (2025) or the provider enrolls only for the purposes of adjudicating Medicare crossover claims under 42 C.F.R. § 455.410(d) (2025). Providers delivering services in the beneficiary's home (such as home care, home health, and pediatric private duty nursing) must be located in Rhode Island only.

b. Maintain a practice location which meets the physical location requirements above. A valid practice location may be a home office where permitted under state law. A valid practice location does not include an international location, virtual office, or mailing-only address such as a P.O. box. Enrollment of telehealth-only providers is not permitted, as providers offering telehealth must also be able to offer services in person to promote beneficiary choice, except in extenuating circumstances as determined by EOHHS due to lack of

in-state capacity for a particular provider type. Each practice location must be appropriately licensed where required under state licensing laws.

c. ~~1.~~ Be fully and appropriately licensed, certified, registered, and/or credentialed, where required by the State, as an active practitioner in good standing by the agency or board overseeing the specific provider type;

d~~2~~. Be registered with appropriate state and federal agencies to prescribe controlled substances, for any provider type that is legally authorized to write prescriptions for medications;

e~~3~~. Be certified to participate in the Medicare program, if the provider type is recognized by Medicare;

f. Never have been the subject of any disciplinary action, sanction, limitation, or restriction imposed by any state agency, federal agency, or board;

g. ~~and/or n~~Never have had common parties in interest (immediate family, financial, or close business connection) with any provider subject to any disciplinary action, sanction, limitation, or restriction imposed, whether or not the action was imposed by any state agency, federal agency, board, the Rhode Island Medicaid program, or a state Medicaid program;

h~~g~~. Never have purchased or otherwise obtained its practice or business entity from any provider suspended or terminated from participation in the Rhode Island Medicaid program due to violations of applicable laws, rules, or regulations; or from a provider that is currently subject to a withholding of Medicaid payments for a credible allegation of fraud or who terminates or has its Medicaid participation terminated while subject to such a withholding of Medicaid payments;

i~~h~~. Cooperate with the Rhode Island Medicaid program during any application, revalidation of enrollment, or other review process, such as responding to inquiries, permitting access, facilitating site visits, and submitting fingerprints, as determined by EOHHS;

j~~i~~. Not be subject to a moratorium on enrollment imposed in accordance with 42 C.F.R. § 455.470 (2025~~1~~); and

k~~j~~. Not have any evidence of a disqualifying conviction that is revealed during a national criminal records check or otherwise revealed during EOHHS' provider risk screening process.

C. Enrollment Application

1. To initiate the provider enrollment or revalidation process, each provider shall submit a complete application to EOHHS. The application is electronic only and purged if not completed within thirty (30) days. A separate application is required for each provider type and National Provider Identifier (NPI). A complete application includes the submission of:

    a. Identifying information such as: legal and business name(s), specialties, all practice location(s), date of birth (if applicable), Taxpayer Identification Number (TIN) (Social Security Number (SSN) for individuals or Employer Identification Number (EIN) for organizations), and NPI (if the provider qualifies to obtain an NPI).

    b. A W-9 form signed and dated by an authorized agent within no more than thirty (30) days prior to submission. A W-9 form is only required for fee-for-service providers receiving payments directly from EOHHS. A new W-9 is only required if the information changes. The legal name and TIN on the W-9 must match the enrollment application.

    c. Bank account information as required for Electronic Funds Transfer (EFT) as described in § 1.6(I) of this Part.

    d. Proof of credentials such as licensure, certification, and/or registration as applicable to the provider type, including expiration date. This includes Drug Enforcement Administration (DEA) certificate of registration and Clinical Laboratory Improvements Act (CLIA) certification, where applicable.

    e. Disclosures for organizational providers under § 1124 of the Social Security Act, 42 U.S.C. § 1320a-3, and 42 C.F.R. Part 455, Subpart B (2025), such as:

        i. Ownership and control. Providers shall disclose the legal name, all addresses, SSN or EIN, and date of birth (where applicable) for: persons or organizations with five percent (5%) or more ~~overall~~total direct and/or indirect ownership interest in the provider; persons with control interests, defined as officers and directors of a provider that is organized as a corporation or trustee of a non-profit, regardless of their number and whether they serve in a paid or unpaid capacity; and any managing employees of the provider for the line of business applicable to the provider type.

        ii. Family relationships. Providers shall disclose any family relationships (spouse, parent, child, or sibling) between

people with ownership or control interests in the provider or a subcontractor.

iii. Ownership of subcontractors. The legal name, all addresses, and EIN for any subcontractor in which the provider has a five percent (5%) or more direct or indirect ownership interest.

iv. Significant business transactions. Full and complete information about ownership of any subcontractor with whom the provider has had any significant business transactions, as defined at 42 C.F.R. § 455.101 (2025), during the twelve (12) month period preceding the application date and about any significant business transactions between the provider and any wholly owned supplier or subcontractor in the five (5) year period preceding the application date.

v. Affiliations. The name of any other disclosing entity (other provider, fiscal agent, or managed care organization) in which an owner also has an ownership or control interest and any affiliation between an owner, person with a control interest, or managing employee and another provider within the previous five (5) years that has been sanctioned by Medicare, EOHHS, or another state Medicaid agency.

vi. Criminal convictions relating to federal programs. Whether any owner, person with a control interest, managing employee, or authorized agent of the provider has been convicted of a criminal offense related to that person's involvement in any Medicare, Medicaid, or program under Title XX of the Social Security Act, 42 U.S.C. § 1397-1397n-13, since the inception of these programs. Under 42 C.F.R. § 455.416 (2025), EOHHS must deny a provider's enrollment if any person with a five percent (5%) or more ownership interest has been convicted of such a criminal offense within the last ten (10) years. EOHHS may deny a provider's enrollment if such conviction occurred more than ten (10) years prior depending on the nature and severity of the conviction and relevance to the provider's current enrollment application.

vii. Nursing facilities. Nursing facilities shall provide additional disclosures as required under 42 C.F.R. § 455.104(e) (2025).

f. Signature. The application and supporting documents shall be signed by an appropriate authorized agent.

g. Application fee. Newly enrolling and revalidating providers subject to the application fee must pay the fee as required under § 1866(j) of the Social Security Act, 42 U.S.C. § 1395cc(j), and 42 C.F.R. § 455.460 (2025) with each application. The amount of the fee is determined by CMS based upon increases in the Consumer Price Index for All Urban Consumers (CPI-U). An application fee is required per application for the following organizational providers:

Adult Day Health	Home Health Agency
Ambulance	Home Meal Delivery
Assisted Living Residence	Home Stabilization
CCBHC	Hospice
CEDARR Family Center	Hospital
Center of Excellence	Independent Laboratory
CHW	Indian Health Service
CMHC/Rehabilitation	Intermediate Care Facility
DCYF Provider	LEA
DDO	Lead Center
Dialysis Center	Nursing Facility
DME/PERS	Pediatric Private Duty Nursing
Early Intervention	Pediatric Therapeutic Service
Emergency Behavioral Health	Peer-Based Recovery
Federally Qualified Health Center	Personal Choice Fiscal Intermediary
Freestanding Ambulatory Surgical Center	Pharmacy
Habilitation - Day Program	PRTF
Habilitation - Group Home	Rural Health Clinic
HBTS	Shared Living Agency

Formatted: Indent: Left: 0", First line: 0"

Formatted Table

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0", First line: 0"

Home Care Agency Substance Use Rehabilitation

Formatted: Indent: Left: 0", First line: 0"

i. The application fee is charged once per enrollment and application round. EOHHS does not charge the fee per attempt at each enrollment stage or for associated individual providers. For example, if a newly enrolling provider submits an application for a single provider type but the first attempt is denied for incompleteness, and then submits a second, complete application, the provider is required to pay one application fee for the initial enrollment attempt. If the provider applies for multiple provider types subject to the fee, the fee is assessed for each application as these are separate enrollments. The application fee is non-refundable, even if the provider is ultimately not enrolled. Once the provider revalidates, a new application fee is assessed. If the provider enrolls under a second provider type, a new application fee is assessed.

ii. Exceptions. Providers are not required to pay an additional application fee if: (1) the provider is enrolled in Medicare as the same provider type and with the same name, TIN, practice location(s) (for moderate-risk and high-risk providers), and ownership information, regardless of when or whether the provider paid the fee to Medicare; or (2) if the provider submits proof of payment to enroll as the same provider type with another state Medicaid agency within the last five (5) years.

iii. Hardship exemption. Providers may request a waiver of the application fee requirement by requesting a hardship exemption. Hardship requests are reviewed on a case-by-case basis by EOHHS and must be approved by CMS under § 1866(j)(2)(C)(ii) of the Social Security Act, 42 U.S.C. § 1395cc(j)(2)(C)(ii). A hardship request must contain a letter that describes the hardship and why the hardship justifies an exemption from the application fee requirement, along with supporting financial documentation that demonstrates financial hardship (tax returns, financial statements, cost reports, cash flow statements, bank statements, etc.). The hardship request must be approved by CMS following review and approval by EOHHS.

D. Provider Screening Under §§ 1866(j) and 1902(a)(77) of the Social Security Act, 42 U.S.C. §§ 1395cc(j) and 1396a(a)(77), and 42 C.F.R. Part 455, Subpart E (2025).

1. As part of provider enrollment and revalidation, EOHHS performs a screening of all providers, including persons with ownership or control interests and managing employees of the provider. The purpose of screening is to ensure that providers meet all State and federal requirements for enrollment and/or continued participation as a provider in the Medicaid program and to ~~mitigate the risk of~~prevent fraud, waste, and abuse. The screening process corresponds to the provider's classification as a limited-risk provider, moderate-risk provider, or high-risk provider, as determined by EOHHS. If a provider could fit within more than one (1) risk level, the highest level of screening shall be applicable. The information gathered during this screening shall impact eligibility for participation as a Medicaid provider, as described herein.

2~~B~~. Minimum screenings. EOHHS performs the minimum screenings required by State and federal law and regulations for all providers as follows ~~for each risk level.~~ :

a. Qualifications: Verifies that the provider meets all applicable state and federal requirements for the provider type prior to making an enrollment determination.

b. Licensure: Verifies the license is active, valid, and that there are no current limitations on the license, such as probationary status, provisional status, or limited prescribing authority (42 C.F.R. § 455.412 (2025)).

c. Federally required screenings: Conducts federal database checks, including the Social Security Administration's Death Master File (DMF), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM), CLIA, and Medicare/Medicaid termination database (DEX). Providers listed on the DMF, LEIE, SAM, or DEX are rejected under § 1902(a)(39) of the Social Security Act, 42 U.S.C. § 1396a(a)(39). Providers are encouraged to review the LEIE to check their own employees and contractors for exclusions.

i. NPI Type. For organizational (facility and group) providers, the NPI must be a Type 2 (organizational) NPI. For individual providers, the NPI must be a Type 1 (individual) NPI.

d. TIN: Verifies the TIN with the Internal Revenue Service (IRS).

3. Site visits. For moderate-risk and high-risk providers, under 42 C.F.R. § 455.432 (2025), ~~federal law requires~~ EOHHS performs ~~an~~ unannounced site visits for each newly enrolling provider, revalidating provider, or enrolled provider changing or adding a new practice location. All site visits

are in person; remote site visits are not permitted. EOHHS may disclose that a site visit is required but to maintain impartiality and integrity does not disclose the specific date and time of any site visits.

a. The purpose of the site visit is to verify the accuracy of the information submitted to EOHHS as part of the provider's application and evaluate the provider's qualifications and satisfaction of Medicaid requirements. Specifically, EOHHS evaluates the following:

i. Physical location: The practice location is legitimate, accessible, and consistent with the information provided on the enrollment application and the requirements of this Part.

ii. Signage: There are public facing signs clearly identifying the business.

iii. Operating hours: The provider is open during posted business hours.

iv. Application verification: Observations at the site are consistent with the information contained in the enrollment application, including credentials and disclosures.

v. Key personnel: An authorized agent facilitates the visit and responds to any questions regarding the enrollment application.

vi. Operational status, including adequate staffing. EOHHS cannot approve a provider to begin billing without confirmation that the provider is actively conducting business in conformance with state and federal rules or ~~poised~~prepared to begin operating in accordance with these rules immediately upon approval. A provider comprised only of administrative staff is not considered operational. Established providers shall demonstrate that direct care staff are trained, qualified, appropriately performing duties associated with the provider type, appropriately supervised, and sufficiently documenting services rendered. Newly opening providers shall demonstrate appropriate business models in place to credential, train, and supervise staff and at least one (1) qualified direct care staff person hired or identified and ready to hire upon approval by EOHHS.

vii. Facilities: Utilities and equipment are clean, safe, accessible, and consistent with the expectations and requirements of the provider type and patient needs.

viii. Recordkeeping. Patient and staff records are securely stored in compliance with federal and state privacy, confidentiality, and retention rules. Medicaid patient records are available to review upon request by EOHHS and adequately support the need for services and the nature of services that are delivered in accordance with state and federal rules. If the provider does not have existing Medicaid patients, the provider must demonstrate compliance with medical documentation and confidentiality requirements through documentation policies, procedures, and templates.

ix. Privacy. Communications are secure and the provider does not share space with unrelated businesses unless properly separated to maintain patient privacy and confidentiality.

x. Billing practices. Billing policies and practices demonstrate understanding of state and federal requirements and that claims for Medicaid payment are based on sufficient documentation of services rendered.

xi. Confirmation. The authorized agent of the provider shall sign an attestation indicating that the individual is authorized to represent the provider regarding the provider's Medicaid enrollment application and acknowledging that the site visit occurred on the specified date.

xii. Photographs. The provider shall permit EOHHS to document photographs of physical attributes at the site, not including clients or personnel onsite, as needed to document compliance with this section.

b. Two (2) attempts. If the site cannot be accessed upon the first attempt, EOHHS conducts a second unannounced site visit on a different day of the week and at a different time of day to attempt contact with the provider. The site visit is denied if the second attempt is unsuccessful.

c. Opportunity to cure. If the site can be accessed by EOHHS but the provider does not demonstrate full compliance with the requirements of this Part, EOHHS identifies the specific deficiencies in writing and provides an opportunity to resolve the deficiencies within thirty (30) days. EOHHS conducts a follow up site visit upon written notification from the provider that the identified deficiencies have been cured.

d. If EOHHS identifies through the site visit that the provider's application was not complete due to inadequate disclosures or false

or misleading information, the application is denied as incomplete and the provider must reapply.

e. Failure to pass the site visit, cooperate during the on-site inspection, or to permit access to the site is grounds for denial or termination.

4. Fingerprinting and national background check. For high-risk providers, ~~C. For the following providers,~~ ~~and if a~~ high-risk ~~provider entity all managing employees and~~ state and federal law require a national criminal records check supported by fingerprints, conducted through the Rhode Island Office of Attorney General (42 C.F.R. § 455.434 (2025) and R.I. Gen. Laws § 42-7.2-18.1). This requirement applies to individual high-risk providers, managing employees of organizational high-risk providers, and persons with a five percent (5%) or greater direct or indirect ownership interest in an organizational high-risk provider. ~~such providers, state and federal law require a national criminal records check supported by fingerprints is required under 42 C.F.R. § 455.434 (2025) and R.I. Gen. Laws § 42-7.2-18.1, conducted through the Office of Attorney General.~~: Fingerprinting must be completed and satisfy the requirements of this Part prior to any site visits. Fingerprints shall be valid for a five (5) year period from the date of the fingerprint.

~~a~~1. ~~Providers designated by the Centers for Medicare and Medicaid Services (CMS) as high categorical risk;~~

b~~E~~. Fingerprinting results. EOHHS is automatically notified by the Rhode Island Office of Attorney General whether the individual is Qualified, Not Qualified, or No Decision. The individual must receive a Qualified result to proceed with provider enrollment. If the result is No Decision, the individual must submit to additional fingerprinting. Providers cannot enroll if the result is Not Qualified, unless EOHHS approves a Good Moral Character exception as specified in this Part. ~~Fingerprints shall be valid for a five (5) year period.~~

c. Rap ~~b~~Back Program. Individuals who receive a national criminal background check through the fingerprinting system are enrolled in the Record of Arrest and Prosecution Back (Rap Back) ~~rap back~~ program which monitors for continued criminal activity for five (5) years after the date of the fingerprint. New disqualifying convictions identified through the Rap Back program ~~rap back~~ shall result in termination by EOHHS, unless granted a Good Moral Character exemption.

d. Good Moral Character. Any individual who is Not Qualified ~~must~~shall be denied enrollment or terminated. However, under R.I.

Gen. Laws §§ 42-7.2-18.2 and 42-7.2-18.3, EOHHS may permit enrollment of a provider with a Not Qualified decision upon request through the Good Moral Character (GMC) exemption process. The individual must obtain a copy of their full national criminal record from the Rhode Island Office of Attorney General which identifies the disqualifying conviction(s) and provide a copy to EOHHS along with a written request which explains the circumstances of each disqualifying conviction and the basis for why the convictions do not present a risk to patient health and welfare or the integrity of the Rhode Island Medicaid program.

i. Eligibility for GMC. An individual may request a GMC review if all disqualifying convictions are conditionally allowed as follows:

Conviction Type	Mandatory Disqualification	Conditionally Allowed
Abuse, neglect, or exploitation	Yes	No
Violent offenses (homicide, assault)	Yes	No
Healthcare fraud under § 1128(a) of the Social Security Act, 42 U.S.C. § 1320a-7(a)	Yes	No
Theft, financial, or property offenses	No	Yes, five (5) years post-conviction
Drug offenses	No	Yes, five (5) years post-conviction

ii. Required supporting documentation. The individual must submit a personal statement explaining the circumstances of each disqualifying conviction, rehabilitation, and personal growth and a justification for why the individual does not present a risk to the Medicaid program along with at least two (2) letters of support, including one from a professional reference (e.g., employer, educator, mentor).

iii. EOHHS review process. EOHHS reviews GMC requests on a case-by-case basis based upon severity, volume,

Formatted Table

Formatted: RICR Paragraph 4

frequency, time since the conviction, age of the individual at the time of conviction, relevance to provider duties, whether there are any pending charges, and evidence of rehabilitation.

E. Managed Care Providers

1. Providers seeking initial or continued participation in a managed care provider network must meet all Medicaid provider requirements and be screened and enrolled by EOHHS in accordance with this Section and § 1932(d) of the Social Security Act, 42 U.S.C. § 1396u-2(d). Managed care providers may be subject to additional credentialing requirements as determined by the managed care organization.

F. Reciprocity

1. Reciprocity with Medicare. EOHHS accepts screening results from Medicare in lieu of performing separate screening activities identified in § 1.6(D) of this Part if: (1) the provider is the same in Medicare and Medicaid and (2) the provider is in "approved" status according to Medicare enrollment records. EOHHS validates this information directly with Medicare's enrollment database, Provider Enrollment, Chain, and Ownership System (PECOS). If the provider is not the same, or the provider is not in "approved" status in PECOS, EOHHS performs a separate screening in accordance with § 1.6(D) of this Part.

   a. The provider is considered the same in Medicare and Medicaid if the following data points match:

      i. Provider Type

      ii. Legal Name

      iii. TIN

      iv. NPI

      v. Practice Location(s)

      vi. Ownership and control disclosures

      vii. Managing employee disclosures

2. Reciprocity with other state Medicaid agencies. EOHHS may accept site visit results from another state Medicaid agency for a provider located out of state if out-of-state enrollment is permitted in accordance with this Part and Part 20-00-3 of this Title; the provider is of the same or comparable provider type; the provider otherwise meets the requirements of this part,

and EOHHS determines that screening activities by the other state were completed in accordance with this Part. EOHHS does not accept the results of the remaining screening activities from another state and does not accept reciprocity for providers located in Rhode Island or a bordering community. For high-risk providers, EOHHS does not accept fingerprinting results from another state.

G. Provider Agreement

1. Providers are required to sign the Medicaid provider agreement as part of the enrollment and revalidation process as required by § 1902(a)(27) of the Social Security Act–, 42 U.S.C. § 1396a(a)(27), and 42 C.F.R. § 431.107 (2025). This includes agreement to observe the requirements of this Part and all other state and federal laws, rules, and regulations; practice sound fiscal and billing practices; retain complete records regarding the delivery Medicaid services for a minimum of ten (10) years; notify EOHHS of changes in information; comply with audit processes; and furnish information and records upon request by EOHHS. The provider agreement must be signed by an authorized agent.

H. Trading Partner

1. Providers must register as a trading partner to submit claims electronically. The provider remains responsible for the accurate submission of electronic claims by an employee or subcontractor on behalf of the provider.

2. Paper claims are also accepted.

I. Electronic Funds Transfer

1. EOHHS does not issue paper checks for claims payment. All payments to providers are direct deposited electronically through Electronic Funds Transfer (EFT). Enrollment in EFT is mandatory. Providers shall authorize EFT by designating a direct deposit account and providing a voided check or letter from the financial institution to verify the direct deposit account.

J. Effective Date of Enrollment

1. Unless an exception applies as described herein, the effective date of provider enrollment is prospective from the date the provider submits a complete application. If the provider's application is returned for missing or incomplete information, the effective date of enrollment is delayed until the date the application is complete.

2. EOHHS recognizes a different effective date in the following cases without regard to the date of complete application:

i. Newly enrolling moderate-risk and high-risk providers: The effective date of enrollment is the date on which EOHHS conducts the site visit that is approved.

ii. Change in ownership for Medicare-certified providers: The earliest effective date of enrollment under the new ownership (buyer) is the date EOHHS receives confirmation of Medicare approval of the new ownership. EOHHS permits billing through the seller until the change of ownership is approved by CMS if there is an agreement between the parties regarding the transfer of payments from the seller to the buyer. EOHHS may recognize a later effective date upon request by the provider, such as the first of the month after this confirmation is received, for providers that bill monthly.

iii. Retroactive provider enrollment: EOHHS may approve a retroactive effective date (backdated enrollment) in extenuating circumstances where an emergency service or lifesaving treatment was provided to a Rhode Island Medicaid recipient before the provider had an opportunity to submit an enrollment application, in particular by out-of-state providers, or in cases of a successful appeal. Retroactive enrollment is only approved if the provider had the proper credentials on the requested effective date. All backdate requests are evaluated on a case-by-case basis and must include information about the Medicaid recipient(s) served and the date and nature of the services that were provided.

K. End Date of Enrollment

1. For providers required to maintain a license or certification, the provider's enrollment automatically terminates upon the expiration of the license or certification. This end date may be extended by the submission of renewal information prior to the expiration date. Updated licensure or certification does not require a full reapplication and re-screening. If there is a lapse in license or certification or the provider does not timely update EOHHS with the extended license date, the provider's enrollment is automatically terminated and the provider must reapply with the new license or certification.

2. For providers transferring ownership to a new NPI or TIN under § 1.6(J) of this Part, the seller's enrollment is terminated one (1) day prior to the effective date of the buyer's enrollment.

3. For voluntary terminations, the end date is established by the provider.

4. For involuntary terminations, the end date is established in the notice by EOHHS.

L. Ongoing Checks

1. In accordance with 42 C.F.R. § 455.436 (2025), EOHHS conducts monthly checks of the LEIE, SAM, and DEX to continuously validate enrolled providers' credentials. Any information revealed by these checks is processed in accordance with this Part.

M. Changes in Information

1. Providers shall maintain up-to-date enrollment records with EOHHS. Generally, changes in information regarding information in the enrollment file must be reported within thirty-five (35) days of the change, along with supporting documentation to validate the request, as needed, with the following exceptions:

   i. Change in ownership. Changes in ownership requiring the issuance of a new NPI and/or TIN require notification to EOHHS through the submission of a new application. A complete application must be submitted on the effective date of the change in ownership, including in cases where Medicare approval is pending, to avoid disruption in payments. Payments may be disrupted if timely notification of the change is not provided.

   ii. Change in practice location. For moderate-risk and high-risk providers, a change or addition of practice location requires a site visit in accordance with § 1.6(D)(3) of this Part. Providers shall submit a change of address request to EOHHS at least thirty (30) days prior to the scheduled start date of the new practice location for EOHHS to conduct a site visit. If adequate notice of the new practice location is not provided, EOHHS may suspend or deny payments for the period of time the new location is in operation without an approved site visit.

   iii. Adverse action. Providers shall report adverse actions against their credentials (license, certification, etc.) or sanctions by Medicare or another state Medicaid program within seven (7) days.

   iv. Closure or voluntary termination. Providers with active Medicaid patients shall notify EOHHS of a closure or voluntary termination at least thirty (30) days prior to the anticipated end date to ensure continuity of care. Providers shall not abandon patients and must provide patients with at least thirty (30) days' advance notice, including information about alternative provider options, and facilitate the transfer of patients to a new provider.

N. Revalidation

1. All providers must revalidate enrollment at least every five (5) years under 42 C.F.R. § 455.414 (2025). This includes submission of a new provider

enrollment application, disclosures, and screening activities as described in this Part.

2. EOHHS ~~has established~~uses a rolling calendar of revalidation activities depending on the provider type and delivery system:

i. Fee-for-service providers are revalidated in waves based upon provider type. Revalidation activities occur every five (5) years and begin in the fourth year to ensure completion of the revalidation process by the fifth year, with the following exceptions:

a. Newly enrolling providers: A newly enrolling provider's first revalidation may occur sooner than five (5) years from the initial enrollment date. For example, if the revalidation years for Provider Type A are 2025 and 2030, a provider that newly enrolls under Provider Type A in 2027 is included in the 2030 revalidation wave.

b. CCBHC: CCBHC providers are revalidated every three (3) years, with the first revalidation in 2027.

3. Managed care organization (MCO) and OPR--only providers that do not participate in fee-for-service are revalidated every five (5) years from the initial enrollment date regardless of provider type. Revalidation activities begin in the fourth year to ensure completion of the revalidation process by the fifth year. For example, an MCO-only provider initially enrolling in 2025 is revalidated beginning in 2029 for completion by 2030 and an MCO-only provider initially enrolling in 2026 is revalidated beginning in 2030 for completion by 2031, even if both are the same provider type.

4. ~~Payments are suspended during any gaps between~~ If the provider fails to meet the revalidation due date, EOHHS suspends payments until ~~and the actual date~~ the revalidation is completed, subject to the notice requirements of this Part.

O. Continuity of Care

1. If a provider's enrollment is terminated, regardless of whether the termination is voluntary or involuntary, providers must ensure continuity of care. Providers shall not abandon patients and must provide patients with at least thirty (30) days' advance notice, including information about alternative provider options, and facilitate the transfer of patients to a new provider.

1.7 ~~1.7~~ Provider Eligibility – Denial of Eligibility ~~Criteria~~

A. A provider that does not meet the requirements of § 1.6 of this Part may not participate in the Rhode Island Medicaid program. A provider application may be denied for:

1. Failure to complete the application process;

2. ~~To be eligible to participate in the Rhode Island Medicaid program as any provider type, a provider must:~~

3. Failure to cooperate with screening, including submitting fingerprints within thirty (30) days of EOHHS' request and permitting access for site visits at any practice locations;

4. Criminal convictions under Medicare or Medicaid within the last ten (10) years;

5. Other disqualifying convictions unless EOHHS approves a GMC exemption;

6. Involuntary termination by Medicare or another state Medicaid or CHIP program on or after January 1, 2011;

7. Affiliation with entities presenting undue risk of fraud, waste, or abuse to the Medicaid program, based upon the ~~degree of affiliation~~ factors listed in 42 C.F.R. § 455.107 (2025), and knowledge of or participation in prior sanctionable violations; or

8. Submission of false or misleading information or omission of required information during the application process.

~~1. Be [illegible]~~

A. A provider may voluntarily terminate enrollment with the Rhode Island Medicaid program at any time, subject to advance notice and continuity of care requirements as described in this Part.

Formatted: Indent: Left: 0.5", First line: 0"

1.9 Provider Eligibility – Involuntary Termination ~~of Participation for Ineligibility~~

A. When an enrolled provider fails or ceases to meet any ~~one (1) or more~~ of the State or federal eligibility criteria applicable to such provider, the provider's participation in the Rhode Island Medicaid program may be terminated by EOHHS.

B. If the provider fails to revalidate within the timeframe required by EOHHS, or if the circumstances described in 42 C.F.R. § 455.416 (2025) apply, termination is required.

C. A provider may be involuntarily terminated as an administrative sanction as specified in § 1.11 of this Part.

D. If ~~such~~ a termination is based upon a finding, ruling, conviction, decision, order, notification, or statement of any nature (including an agreement with the provider) by any federal, state, or quasi-public board, department (other than EOHHS), or other agency or another state's Medicaid program that revokes, voids, suspends, or denies the issuance, renewal, or extension of a license, certificate, or other statement of qualification that constitutes a statutory prerequisite or other eligibility criterion, the correctness or validity of the action taken by the issuing agency will be presumed, the termination will be effective as of the earliest date on which the provider failed or ceased to meet any of such criteria, and EOHHS shall not afford a hearing as to the correctness or validity of such action.

E. If ~~such~~ a termination is based solely upon a determination of ineligibility by EOHHS, the provider shall be afforded notice and an opportunity for hearing in substantially the manner set forth in ~~§ 1.10~~Section 1.13 of this Part, and any termination will be effective as of the date ~~of receipt of~~specified in the notice thereof.~~.~~

A. When a provider is the subject of a notice by the United States Department of Health and Human Services (HHS) requiring the provider's suspension or the denial, termination, or refusal to renew a provider contract pursuant to § 1902(a)(39) of the Social Security Act, 42 U.S.C. § 1396a(a)(39), or any other section of the Social Security Act, 42 U.S.C. §§ 301-1397mm, the provider's participation in the Rhode Island Medicaid program shall be suspended or its provider contract shall be denied, terminated, or not renewed in accordance with the HHS notice. ~~The Rhode Island Medicaid program agency~~EOHHS shall not afford a hearing to the provider as to the correctness or validity of the action taken by HHS.

~~1.10~~ 1.11 Medicaid Provider Administrative Sanctions

A. In accordance with R.I. Gen. Laws Chapter~~s~~ 42-35 (The Administrative Procedures Act), Chapter ~~and~~ 40-8.2 (Medical Assistance Fraud), and § 42-7.2-19 (Program Integrity Division), the EOHHS is authorized to establish administrative procedures to impose sanctions on Medicaid providers ~~of health services and supplies~~ for any violation of the Rules, Regulations, standards, or laws governing the Rhode Island Medicaid Program. The Federal Government mandates the development of these administrative procedures ~~for the~~under Title XIX of the Social Security Act, 42 U.S.C. § 1396a-1396w-8, ~~Medicaid Program~~ in

order to ensure compliance with §§ 1128 and 1128A of the Social Security Act, 42 U.S.C. §§ 1320a-7 and 1320a-7a, which imposes Federal penalties for certain violations.

B. Sanctionable Violations. All providers of Medicaid and CHIP-funded health care services and supplies are subject to the R.I. Gen. Laws and the Rules and Regulations governing the Medicaid program. Sanctions may be imposed by ~~the~~ EOHHS against a Medicaid provider for any one (1) or more of the following violations of applicable law, Rule, or Regulation:

1. Presenting or causing to be presented for payment any false or fraudulent claim for medical services or supplies.

2. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than to which the provider is legally entitled.

3. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

4. Failure to disclose or make available to ~~the Single State Agency~~EOHHS or its authorized agent records of services provided to Medicaid recipients and records of payments made for such services.

5. Failure to submit required reports.

6~~5~~. ~~F~~Failure to provide and maintain quality services to Medicaid recipients within accepted medical or professional community standards as determined by an official body of peers.

7~~6~~. Engaging in a course of conduct or performing an act deemed improper or abusive of the Medicaid Program or continuing such conduct following notification that said conduct should cease.

8~~7~~. Breach of the terms of a Medicaid provider agreement or failure to comply with the terms of the provider certification of the Medicaid claim form.

9~~8~~. Overutilizing the Medicaid Program by inducing, furnishing, or otherwise causing a beneficiary to receive services or supplies not otherwise required or requested by the beneficiary.

10~~9~~. Rebating or accepting a fee or portion of a fee or charge for a Medicaid beneficiary referral.

11~~10~~. Violating any provisions of applicable Federal and State laws, Regulations, plans, or any Rule or Regulation promulgated pursuant thereto.

12~~11~~. Submission of false or fraudulent information in order to obtain provider status, including falsification or omission of required disclosures.

13~~12~~. Violations of any laws, Regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

14~~13~~. Any disqualifying conviction or other criminal conviction relevant to the provision of care.~~.~~

15~~14~~. Failure to meet standards required by State or Federal laws for participation such as licensure, professional standards, and certification.

16. Poor quality of care which presents a risk to beneficiary health or safety.~~.~~

17~~15~~. Exclusion from the Federal Medicare program or any State health care program administered by the EOHHS because of fraudulent or abusive practices.

18~~16~~. A practice of charging beneficiaries or anyone acting on their behalf for services over and above the payment made by the Medicaid Program, which represents full and total payment, except for any cost sharing amounts determined and authorized by EOHHS.

19~~17~~. Refusal to execute a provider agreement when requested to do so.

20~~18~~. Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from ~~the Single State Agency~~EOHHS.

21~~19~~. Formal reprimands or censure by an association of the provider's peers for unethical practices.

22~~20~~. Suspension or termination from participation in another governmental health care program under the auspices of Workers' Compensation, Office of Rehabilitation Services, Medicare, or any State program administered by the EOHHS or one of the agencies under the EOHHS umbrella.

23~~21~~. Indictment for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

24~~22~~. Failure to produce records as requested by ~~the State Agency~~EOHHS.

25~~23~~. Failure to repay or make arrangement for the repayment of identified overpayments or otherwise erroneous payments within the timeframe specified by EOHHS.

26. Failure to respond to information requests within the timeline requested by EOHHS regarding provider enrollment or billing activities.

27. Knowingly selling or allowing another individual or entity to use the provider's billing number or NPI, other than a valid reassignment of benefits.

28. Using another provider's billing number or NPI without a valid reassignment of benefits.

29. Providing services to a patient with whom the provider has a conflict of interest, unless specifically permitted under State law or regulation.

30. Failure to permit access by EOHHS to provider locations.

31. Failure to adhere to the terms of the provider agreement.

C. Provider Sanctions. Any one (1) or more of the following sanctions may be imposed against providers ~~who~~ that have committed any one (1) or more of the sanctionable violations above. EOHHS utilizes a structure of progressive discipline based upon the nature and severity of a provider's actions such as the duration of the behavior, financial exposure, and level of cooperation by the provider in recognizing and remediating the issue, unless a sanction is specifically required under 42 C.F.R. Part 455 (2025).~~:~~

1. ~~T~~Involuntary termination from participation in the Medicaid program or any State health care program administered by the EOHHS. EOHHS must pursue termination for the mandatory termination reasons identified in 42 C.F.R. § 455.416 (2025).

2. Exclusion from the Medicaid program under § 1902(p) and 42 C.F.R. Part 1002 (2025).

3~~2~~. Suspension of participation in the Medicaid Program or any State health care program administered by the EOHHS or an agency under the EOHHS umbrella.

4

5. Written warning of noncompliance.

6. Corrective action plan(s), presented by EOHHS and agreed to in writing by the provider, to address specific performance issues or deficiencies and the plan and timeframe to rectify such deficiencies.

7~~4~~. ~~Transfer to a provider agreement not to exceed twelve (12) months or the s~~Shortening of an already existing provider agreement.

8~~5~~. Prior authorization required before providing any covered medical service and/or covered medical supplies.

9~~6~~. Monetary penalties.

~~F~~E. Except where involuntary termination or exclusion has been imposed, a sanctioned provider ~~who has been sanctioned~~ may be required to attend a provider education program as a condition of continued participation in any health care program administered by EOHHS.

1. A provider education program will include instruction in:

   a. Claim form completion;

   b. The use and format of provider manuals;

   c. The use of procedure codes;

   d. Key provisions of the Medicaid Program;

   e. Reimbursement rates; and

   f. How to inquire about procedure codes or billing problems.

1.12~~1~~Notice and Appeals Relating to Program Integrity Matters ~~Notice of Violations and Sanctions~~

A. Provider appeals are not considered beneficiary fair hearings as defined by CMS under 42 C.F.R. Part 431, Subpart E (2025). ~~Rather, p~~Providers may have a right of appeal under the Administrative Procedures Act, R.I. Gen. Laws Chapter 42-35.

B. Notice. When the Medicaid agency intends to deny, terminate, or sanction a provider, EOHHS provides written notice to the provider. The notice ~~must~~ includes the following:

   1. A plain statement of the facts or conduct alleged to warrant the intended EOHHS action. If the Medicaid agency is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved and a detailed statement shall be furnished as soon as is feasible.

   2. A statement of the provider's right to a hearing that indicates the provider must request the hearing within fifteen (15) days of the receipt of the notice.

C. Appeals process. The provisions in 210-RICR-10-05-2 relating to the appeals and informal dispute resolution process apply, with the following program-specific provisions for provider appeals:

1. Providers must request an administrative fair hearing within fifteen (15) days of written notice by EOHHS.

2. Informal dispute resolution~~hearing~~. ~~t~~The provider may request ~~an~~ informal dispute resolution, as described at 210-RICR-10-05-2, ~~hearing~~ with ~~the Medicaid agency~~EOHHS while the formal administrative hearing is pending.

3. Aid pending. The provisions of 210-RICR-10-05-2 regarding eligibility for benefits during the appeals period, or "aid pending," do not apply to providers. If the appeal is related to a suspension of payments or termination of provider enrollment and the suspension is lifted or provider enrollment is reinstated, payments may be made for services delivered during the appeal period.

4. Continuances. An ongoing criminal investigation of an issue by the Medicaid Fraud Control Unit (MFCU) or other law enforcement body supersedes administrative appeals on the same issue until the investigation is complete. If the investigation is opened after the submission of an appeal, the administrative appeal must be continued indefinitely until such time as the investigation and any associated enforcement proceedings are completed. A provider is not entitled to continued payment until the closure of such proceedings unless a determination of good cause is made under 42 C.F.R. § 455.23 (2025). In all other cases, a matter may be continued at the request of either party in accordance with 210-RICR-10-05-2.

~~A. When the Medicaid agency intends to formally suspend or terminate a provider as a consequence of a sanctionable violation, a notice of violation must be sent to the provider by registered mail. The notice must include the following:~~

~~F~~E. Stay of Order. Orders may be stayed in accordance with R.I. Gen. Laws §§ 42-35-15 and 40-8.2-17.

~~G~~F. Reinstatement. Pursuant to 42 C.F.R. § 1002.214(c) (2025~~1~~), a State may afford a reinstatement opportunity to any provider terminated or suspended at the State's initiative. The provider may only be reinstated to participate in the Medicaid program by the EOHHS, in its capacity as the Medicaid Single State Agency. The sanctioned provider may submit a request for reinstatement to EOHHS at any time after the date specified in the notice of termination or suspension.

~~H~~G1. EOHHS may grant reinstatement only if it is reasonably certain that the types of actions that formed the basis for the original exclusion have not recurred and will not recur. Factors EOHHS will consider in making such a determination are contained in 42 C.F.R. § 1002.215(a) (2025~~1~~).

Formatted: RICR Paragraph 2

~~H~~2. If EOHHS approves the request for reinstatement, ~~it will provide the proper notification to~~ EOHHS notifies the excluded party and all others who were informed of the exclusion, specifying the date when participation ~~will~~ may resume in accordance with 42 C.F.R. § 1002.215(b) (2025~~1~~). If EOHHS does not approve the request for reinstatement, it will notify the excluded party of its decision. Any appeal of a denial of reinstatement will be in accordance with State procedures and not subject to administrative or judicial review.

~~1.12 C. A provider who does not meet the requirements of this section is entitled to a hearing on the issue of eligibility pursuant to the State's Administrative Procedures Act, as found at R.I. Gen. Laws Chapter 42-35, as amended, and in conformance with Part 10-05-2 of this Title, Appeals Process and Procedures for EOHHS Agencies and Programs.~~

A. If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.